



SilverSneakers® fitness program for Medicare Advantage patients

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This just in.....

Clear Claim Connection™ service interruption scheduled for May 2, 2009

McKesson, the vendor that supplies Clear Claim Connection, has advised us that system maintenance to the application is scheduled to occur on May 2, 2009 and will interrupt service from 12:00 a.m. EDT through 1:00 p.m. EDT. During this time, you will not be able to access this application.

*Partners in Health Update*SM is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Program (HMO, PPO, Indemnity, etc.), and/or employer groups. Providers should call Provider Services, listed at right, for the member's applicable benefit information. Members should be instructed to call the Customer Service telephone number listed on their ID card.

The third-party websites mentioned in this publication are maintained by organizations over which IBC exercises no control, and accordingly, IBC disclaims any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised in these third-party sites. URLs presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

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Recently...



NaviNet

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NaviMedix® is now NaviNet®

Same great service. Fresh new look.

For articles specific to your area of interest, look for the appropriate icon:

P

Professional

F

Facility

A

Ancillary



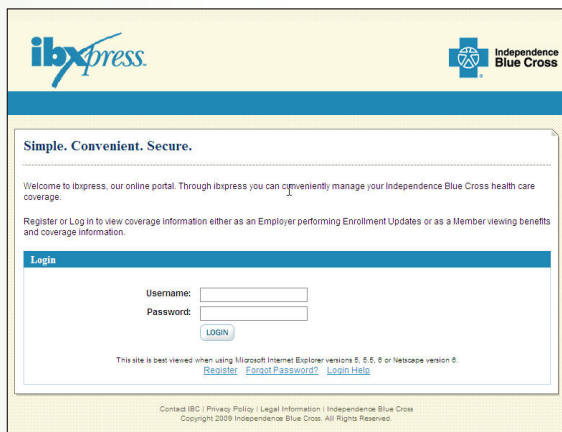
Keystone Health Plan East, Personal Choice®, Keystone 65, and Personal Choice 65SM have an accreditation status of *Excellent* from the National Committee for Quality Assurance (NCQA).

How our member portal helps your patients

Independence Blue Cross is committed to providing the products, tools, and incentives to empower consumers to take an active role in their health care decisions. Each month, we will be spotlighting a different topic to let you know how we are empowering our members to optimize their health and get the best value for their health care dollars.

This month we are highlighting our member portal — a valuable resource for our members to seek out information that can help them stay well and get the most value from their health plan.

Found at www.ibxpress.com, the member portal can be accessed 24 hours a day, seven days a week. Many elements are offered to support our members in creating and maintaining a healthier life. Included is a range of information, from the ConnectionsSM Health Management Programs to personal information about our members' specific benefits plan.



Through our portal, members can complete a Personal Health Profile and receive an instant health summary. They can also choose from several online health education modules, such as stress management, eating a healthy diet, smoking cessation, back pain, and asthma.

Benefits plan information

HMO, PPO, and POS members can view information about their health plan, including their medical copays and summary of benefits. Other options include:

- viewing claims
- finding a provider
- estimating treatment costs

HMO and POS members also have the ability to:

- view open referrals
- find a formulary drug
- manage prescriptions
- compare costs of coverage

Self-service features

What can members do if they lose their member ID card? Through www.ibxpress.com, members can request a new ID card and even print out a temporary one until their official card comes in the mail.

Enrollment, authorization, and claims forms can also be found under the self-service tab.

HMO and POS members can also view and change their current primary care physician within this feature.

Health & You web magazine

Every week, members can get the latest information on general health, fitness, nutrition, parenting, and safety. These articles include information on seasonal topics, such as flu season, to more general topics, such as managing your weight on a budget.

Case Management

Case Management offers our members the assistance of a registered nurse who work directly with those who suffer from a serious illness or medical condition. These nurses are called case managers and they work together with our members and their health care team to provide advocacy, support, education, identification of services and resources, and coordination of services within their benefits plan.

Wellness tools

We offer a number of wellness tools through the portal that can aid our members in improving their health. Some of the tools we provide include:

- a sample walking or jogging program;
- body mass index calculator;
- personalized food pyramid.

Customer Service

Members can always call 1-800-ASK-BLUE for questions and concerns that they have, but our member portal also gives them the option to email a customer service representative. Members can also view frequently asked questions about the website and how to view their benefits information.

Members can access all of these features and many more by logging on to www.ibxpress.com.

Billing



Reminder: Submit Coordination of Benefits information electronically

Providers and facilities may submit Coordination of Benefits (COB) information electronically for professional/facility services using the applicable 837P or 837I format. For instructions on how to bill electronically, please visit www.ibx.com/providers/claims_and_billing/edi/forms.html.

Submitting COB information electronically eliminates the need for paper claims submissions. Claims submitted electronically are processed faster and have a significantly higher *first-pass* adjudication rate, which translates into a faster payment.

For questions concerning electronic billing, please call the eBusiness Help Desk at 215-241-2305 or contact your Network Coordinator.



Products



Medicare Advantage Private Fee-for-Service: maintaining medical records and allowing audits

On January 1, 2008, we introduced Select Advantage, a Medicare Advantage Private Fee-for-Service (PFFS) plan. This plan is a non-network, nonmanaged care product that does not include utilization management or require referrals. However, all services must meet Original Medicare guidelines for coverage and are subject to retrospective review audit.

Except for emergencies, providers have the right to decide whether to treat Select Advantage PFFS members on a patient-by-patient and visit-by-visit basis. A decision to treat a specific member does not require the provider to treat other Select Advantage PFFS members.

If providers choose to treat Select Advantage members, they must maintain timely and accurate medical, financial, and administrative records related to services they provide to Select Advantage members. Unless a longer time period is required by applicable statutes or regulations, the Centers for Medicare & Medicaid Services (CMS) requires that the provider must maintain such records for at least 10 years from the date of service.

Deemed providers must also allow Select Advantage, the Department of Health and Human Services, the comptroller general, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with federal and state privacy laws.

Such records may be used for activities in the following situations: CMS and Select Advantage audits of risk adjustment data; Select Advantage determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; appeals, grievances, and Q10 reviews; and as references in order to make advance coverage determinations.

Medical record reviews will not be used to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

Please visit our website at www.ibx.com/providers/pffs/index.html for additional information. Also, be sure to check future editions of *Partners in Health Update* for additional information about this Medicare Advantage PFFS plan.



Products



Get your Medicare Advantage patients moving with the SilverSneakers® fitness program

As a physician, you know the importance of physical activity for overall health. Regular exercise is particularly important to the well-being of your older adult patients because of the profound effect it can have on their quality of life. Physical activity helps them maintain their ability to live independently and reduces their risk of falling and fracturing bones. In addition, physical activity can also help reduce the risk of heart disease and of developing high blood pressure, colon cancer, and diabetes.¹ More recent evidence links exercise with reduced incidence of dementia and depression.²

If you're looking for a way to motivate your Medicare patients who are members of an Independence Blue Cross (IBC) Medicare plan to get up and get moving, your recommendation and the SilverSneakers® Fitness Program might be all the incentive they need. There is evidence that a physician recommendation can be an important factor leading to patient behavior and lifestyle modifications. There is also evidence that SilverSneakers — the nation's leading exercise program designed exclusively for older adults — gets people more active by offering an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take control of their health.

Here are some of the great features of SilverSneakers that you can share with your patients:

- Through SilverSneakers, your patients will receive a complimentary fitness center membership with access to a variety of participating locations throughout the country.
- Many sites offer such amenities such as fitness equipment, treadmills, free weights, and the signature SilverSneakers Fitness Program classes, designed specifically for Medicare eligibles and taught by certified instructors. A designated staff member will help your patients along the way.
- Regular participation in the SilverSneakers Fitness Program can help your patients with regular physical activity to help them stay healthy and independent.
- SilverSneakers is all about fitness, fun, and friends. The program provides your patients with opportunities to attend educational and health-related seminars while expanding their social network.

As you educate your patients about the importance of including regular physical activity in their weekly routines, be sure to remind them that as a member of IBC, the SilverSneakers Fitness Program is available to them at no additional cost. To learn more about SilverSneakers, visit www.ibx.com/providers/resources/silversneakers.html.

Note: Security 65® and 65 Special members are not eligible for SilverSneakers.

SilverSneakers® is a registered mark of Healthways, Inc., an independent company.

¹www.cdc.gov/nccdphp/sgr/olderad.htm

²Larson EB, Wang L, Bowen JD, McCormick WC, Teri L, Crane P, Kukull W. Exercise is Associated with Reduced Risk for Incident Dementia among Persons 65 Years of Age and Older. *Ann Intern Med*, 2006; 144:73-81.



Products



Individual Personal Choice® summary of benefits changes

Effective June 1, 2009, the benefits language related to our Individual Personal Choice High, Standard, and Prime member benefits programs will be enhanced, clarified, or updated. Please refer to the *Individual Personal Choice Summary of Benefits Changes* which is included with this edition of *Partners in Health Update* for details about the types of services and the nature of the enhancements, clarifications, or preapproval requirements.

If you have any questions, please contact your Network Coordinator.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association



The benefits of using the NaviNet web portal

We offer network providers a way to simplify health care administration through the NaviNet web portal. NaviNet gives providers fast, secure, HIPAA-compliant access to provider and member information, and enables real-time transactions. Best of all, NaviNet is free and requires no additional software.

Some of the administrative tasks that can be performed with NaviNet include:

- confirm eligibility and benefits information, including plan type, coverage dates, copayments, coordination of benefits, preexisting condition clause information, PCP, and PCP-capitated sites (when applicable), for local and out-of-area Blue Plan members;
- retrieve up to two years of historic claims data (including paid, denied, and in-process/pended claims);
- retrieve electronic referrals within 365 days of the referral date;
- submit adjustments for finalized claims;
- submit referrals to the plan and to NaviNet-enabled specialists and facilities electronically (use the optional NaviNet auto-fax feature to fax referrals to specialists and facilities, even to those who are not registered with NaviNet);
- submit drug prior authorization requests for determination and response within 48 hours.

You will need:

- HMO or PPO network participation;
- computer access;
- minimum operating system requirement: Windows® 98 operating system
- Internet access (minimum requirement: Internet Explorer® 5.01, Service Pack 2).

To register you can submit an [online inquiry form](#) or contact Provider Network Services at 215-640-7410.



Removal of estimated length of stay

Beginning in June 2009, we are making a change to how we reply/respond to authorization requests and inquiries. When requesting or checking on the status of an authorization for Independence Blue Cross members through the NaviNet web portal, the *Estimated Length of Stay* field will no longer be provided. This information is not used in making utilization management decisions, therefore, it is not needed. The elimination of the estimated length of stay also applies to precertification requests made through the Health Resource Center.

For questions about this notice, please contact Jamie Stanton, Sr. Director Care Management Operations, at 215-241-4635.

Clinical Alerts now available on the NaviNet web portal

Clinical Alerts, a clinical practice tool designed to help physicians identify patient needs by providing member-specific information, is now available. This new tool is available to primary care physicians (PCPs), OB/GYNs, endocrinologists, and cardiologists and will be expanded over time to include additional specialties.

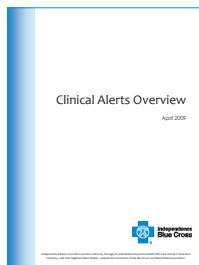
What are Clinical Alerts?

Clinical Alerts are notifications, based on administrative data, that a member has not received a recommended service or medication. They are intended to assist with identifying opportunities for improving clinical quality and outcomes for our members. They do not — nor are they intended to — replace the professional, clinical judgment of the member's treating physician.

Where are Clinical Alerts located?

The alerts are available on the NaviNet web portal through the *Member Eligibility and Benefits Inquiry* screen. When a Clinical Alert has been issued for a member, it will be clearly indicated by a flag in the "Alert" column found on the *Member Eligibility and Benefits Inquiry* response screen.

Req ID	Member Name	Member ID	Product Name	DOB	Relationship	Status	Begin Date	End Date	Alert	R-Panel	DOS
1	DOE, JOHN	Y1H3530001111	Opti Care HMO	01/15/1975	Subscriber	Active	08/01/2005		Y		04/07/2009



How can I learn more?

A detailed, easy-to-read *Clinical Alerts Overview* has been published to provide you with all of the information you will need to understand and take advantage of this new tool. The overview can be found in the *Administrative Tools and Resources* section of NaviNet Plan Central.

Examples of Clinical Alerts

Below are examples of Clinical Alerts that are displayed when certain services or medications have not been provided to the patient. *Note:* Some claim lag time should be expected.

- annual LDL-C (cardiovascular condition)
- annual serum potassium for patients on ACE inhibitors or ARBs, digoxins, and/or diuretics
- annual blood urea nitrogen or serum creatinine for patients on ACE inhibitors or ARBs, digoxins, and/or diuretics
- annual serum concentration level for each anticonvulsant drug prescribed
- annual retinal exam (diabetes)
- annual LDL-C (diabetes)
- annual nephropathy testing which includes one of the following: microalbumin test or evidence of ACE/ARB
- annual chlamydia screening (sexually active females between the ages of 16-25)
- beta-blocker treatment (at least 135 days filled within 180 days after AMI)
- annual HbA1c (diabetes)
- breast cancer screening/mammography in the most current 2 year period (ages 42-69)
- cervical cancer screening/PAP in the most current 3 year period (ages 24-64)
- colorectal cancer screening, either fecal occult blood test (FOBT, FOBI) annually or flexible sigmoidoscopy every 5 years or double contrast barium enema every 5 years or colonoscopy every 10 years (ages 51-75)

As a reminder, providers should contact NaviNet Customer Care at 1-888-482-8057 for assistance with any NaviNet transactions.

Spring 2009 edition of Inside IPP now available

Inside IPP: An Inter-Plan Programs Publication, is our publication for facility and ancillary providers to increase provider awareness of and satisfaction with the BlueCard® Program. The publication introduces new initiatives related to BlueCard processing and highlights plans for improvement.

The spring edition of Inside IPP is now available and features the following articles:

- One-year anniversary of Inside IPP
- Inside IPP provider survey coming soon
- New initiatives: Coordination of Benefits processing changes
- Line, dollar, and unit expansion for claims
- Submitting the BlueCard Coordination of Benefits Questionnaire for out-of-area members
- Reminder: Blues move to automatic crossover for all Medicare claims — all claims will be automatically submitted to the secondary payer

You can read the latest edition as well as find a complete archive of past issues of Inside IPP at www.ibx.com/providers/blue_card. Paper copies of Inside IPP are available at the Provider Supply Line upon request.



Reminder: Submitting the BlueCard Coordination of Benefits Questionnaire for out-of-area members

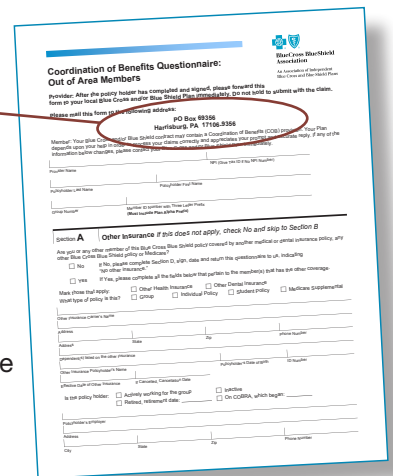
In January 2009, we updated the BlueCard Coordination of Benefits Questionnaire for out-of-area members and streamlined the submission process. Out-of-area members are HMO, Traditional Hospitalization, and PPO members of other Blue Cross® and Blue Shield® plans who travel or live in the Independence Blue Cross (IBC) five-county service area*. This BlueCard Coordination of Benefits Questionnaire should not be used for local IBC members or Federal Employees Program (FEP) members.

To avoid processing delays in claims payments, the provider or office staff must complete the first two fields on the questionnaire: the provider name and NPI. The provider or office staff should ask the out-of-area member to complete the remaining sections of the questionnaire before he or she leaves the office.

If the member chooses to complete the questionnaire outside of the office, he or she should be instructed to return the completed questionnaire to the provider's office. The provider or office staff should immediately forward the completed questionnaire to:

P.O. Box 69356
Harrisburg, PA 17106-9356

This mailing address is prominently printed on the front page of the questionnaire.



Providers should not delay submission of the BlueCard Coordination of Benefits Questionnaire to coordinate with the claim submission. Claims should continue to be sent through your standard submission methods, which are separate from the submission of the BlueCard Coordination of Benefits Questionnaire.

The BlueCard Coordination of Benefits Questionnaire is available at www.ibx.com/providers/blue_card/index.html, as well as in the Reference Material and Reports section on the NaviNet® web portal.

If you have any questions about these important instructions, please contact your Network Coordinator.

Note: Do not use the P.O. Box/ mailing address listed on the BlueCard Coordination of Benefits Questionnaire for any other correspondence. Only completed questionnaires for out-of-area members should be sent to this address.

*The IBC five-county service area includes Philadelphia, Bucks, Montgomery, Chester, and Delaware counties.

Policy notifications posted as of April 16, 2009

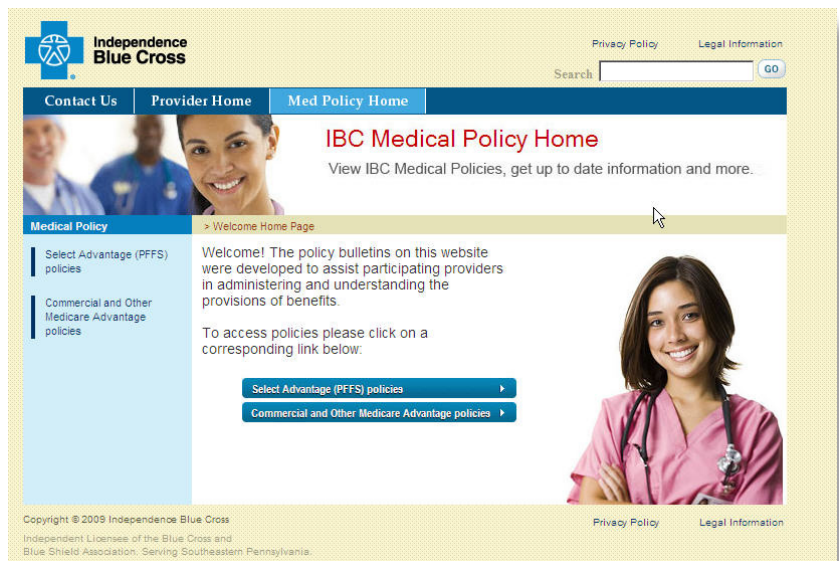
All policies are posted prior to their effective date on our *Policy Notifications* web page. Below is a listing of the policy notifications we have posted to the site as of April 16, 2009.

Policy effective date	Notification title	Notification issue date
May 6, 2009	11.08.28b Breast Duct Lavage, Suction Collection of Nipple Aspirate Fluid, and Breast Duct Endoscopy	April 6, 2009
May 6, 2009	05.00.37b Compression Garments	April 6, 2009
May 6, 2009	11.02.23a Subfascial Endoscopic Perforator Surgery (SEPS)	April 6, 2009
May 13, 2009	02.02.01d Hospice and Respite Care	April 14, 2009
May 15, 2009	05.00.48d Durable Medical Equipment (DME) Not Subject to a Rental to Purchase Maximum	April 15, 2009
May 15, 2009	07.09.02b Salivary Estriol as a Risk Predictor for Preterm Labor	April 15, 2009
May 15, 2009	11.02.01f Treatment of Varicose Veins of the Lower Extremities	April 15, 2009
May 19, 2009	11.05.11a Implantation of Intrastromal Corneal Ring Segments (INTACS)	February 18, 2009
June 2, 2009	11.15.01f Spinal Cord Stimulation (Dorsal Column Stimulation)	March 4, 2009
July 14, 2009	11.16.03d Lung Volume Reduction Surgery	April 15, 2009

To access these notifications and view the policies in their entirety, follow these instructions:

1. Visit www.ibx.com/medpolicy.
2. Select *Accept and Go to Medical Policy Online*.
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *Policy Notifications* from the Medical Policy column on the left sidebar.

Be sure to check back often as the site is updated frequently.



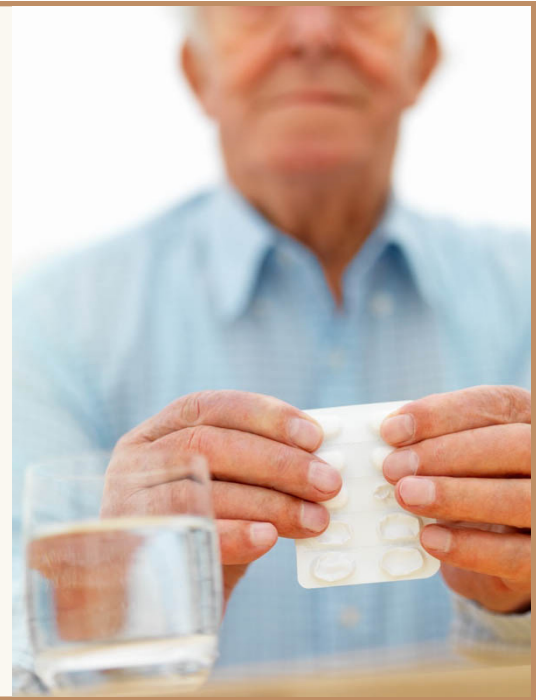
Pharmacy

Medicare Part D formulary changes



As of July 1, 2009, changes may be made to the Medicare Part D formulary for Keystone 65, Personal Choice 65SM, Select Advantage, and Select Option members. For example, as of July 1, 2009, formulary tier and prior authorization changes may occur for some members serviced by FutureScripts[®] Secure.

For updated benefit information, visit www.site65.com, contact your Network Coordinator, or call Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.



Pharmacy

Reminder: Important changes about self-injectable drug coverage coming January 1, 2010



In an effort to provide access to self-injectable drugs with greater value for our commercial HMO, POS, Direct POS, and PPO members, we are changing the way we cover self-injectable drugs, effective January 1, 2010. These changes, in tandem with a series of billing code changes described in this section, are part of our evolving, overall approach to managing specialty pharmaceutical benefits. We will be communicating a series of changes over the next two years, designed so that members are getting the right drug in the right setting at the right time for a good value.

Members received their first notification of these changes in January 2009 and may have questions for you. The following is a brief description of the scheduled changes to help you answer questions that your patients may have.

Starting on January 1, 2010, we no longer will provide benefits for most self-injectable drugs under our medical benefits program. However, if HMO, POS, Direct POS, or PPO members have Independence Blue Cross pharmacy coverage, their self-injectable drugs will continue to be covered under their pharmacy benefits in 2010. If members have prescription coverage from another carrier, they should check their coverage to determine whether their prescription drug plan includes coverage for self-injectable drugs.

The self-injectable drugs that will no longer be covered under medical benefits programs are those that patients typically administer themselves and do not require physician monitoring.

We *will* continue to cover at the appropriate cost-sharing levels, those injectables under the medical benefits program, that:

- cannot be administered without medical supervision;
- are mandated by law to be covered (e.g., insulin);
- are required for emergency treatment under the medical benefits program, such as self-injectable drugs that effectively counteract allergic reactions (e.g., EpiPen[®]).

If you have any questions about these impending changes, please call Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

Reminder: NDC code submission changes effective January 1, 2009

We want to remind you of some changes to the National Drug Code (NDC) submission procedure that went into effect January 1, 2009, as part of our overall approach to managing specialty pharmaceutical benefits.

Please be advised that an edit is now in place to validate the NDC on any paper or electronic claims submitted with an unlisted and/or non-specific drug code. Please review the billing requirements listed below for your applicable provider type. By requesting this detailed drug billing information, we can provide greater transparency for our members and providers. Certain claims for unlisted and non-specific drug codes that are not accompanied by an NDC in the correct format and location will not be processed and will be returned to you for correction and resubmission. Please note that this requirement is applicable to the claim processing date and not the date of service.

For professional providers: Effective January 1, 2009, claims for all unlisted and non-specific drug codes (CPT® or HCPCS) require submission of an NDC in the correct format and location. If the NDC is not submitted in the correct format or is missing, the claim will not be processed and will be returned to you for correction. The complete list of unlisted and non-specific codes that require the submission of an NDC can be found in the January 2009 *Partners in Health Update*.

For home infusion providers: Effective January 1, 2009, all drug claims (not just the unlisted and non-specific CPT or HCPCS codes listed in the January 2009 *Partners in Health Update*) require the submission of an accompanying 11-digit NDC. This includes claims for hemophilia factor products that are currently submitted with specific J codes.

For institutional providers: Scheduled for future release in 2009, all claims for outpatient services containing the following pharmacy revenue codes and an unlisted and/or non-specific (CPT or HCPCS) code will require a valid NDC when submitted: 250-259, 262, 263, 331, 332, 335, 343, 344, and 631-637.

NDC billing information

Please submit the NDC using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (e.g., 12345678911) will also be accepted. Please do not include spaces, decimals, or other characters in the 11-digit string, or the claim will be returned to you for correction prior to processing.

For information on claims submission resolution, please refer to the *Claims Preprocessing Edits Claims Resolution Document* at www.ibx.com/providers/claims_and_billing/edi/forms.html.

If you have questions, please contact your Network Coordinator.

ConnectionsSM Health Management Program provider survey results for 2008

In late 2008, the annual Connections Program provider satisfaction survey was conducted by Kochevar Research Associates, an independent research company. This survey was completed during one-on-one interviews with a select number of providers in our network to glean their opinions of the Connections Health Management Program. The interviews were also used to find out what doctors thought of our Provider Service Specialists (PSS) and the SMART[®] Registry as well as to gather feedback on how Independence Blue Cross can improve the Connections Program.

While the goal of these structured interviews was qualitative, following are some of the resulting statistics:

- Of the providers surveyed, 54 percent expressed interest in the Connections Program.
- Sixty-nine percent had referred some of their patients to Connections.
- Almost 55 percent of providers surveyed said they had patients who reported they spoke with a Health Coach from the Connections Program.
- More than 85 percent of the doctors surveyed said they were aware of the SMART Registry, a semiannual report on providers' Connections-eligible members with asthma, diabetes, COPD, CHD, and heart failure.

Providers stated that personal interactions with a PSS were a major factor in their knowledge of and involvement in the Connections Program. A PSS meets with doctors and office staff to assist in making referrals to the Connections Program and work through the SMART Registry reports.

The doctors included in the survey provided the following suggestions on how to improve the Connections Program:

- Provide more effective communications about Connections.
- Keep communications simple.
- Provide feedback on members actively engaged in health coaching.

For information on the Connections Health Management Program or to speak with a PSS, please call 1-866-866-4694. You can also find additional program information and resources, such as referral forms and handouts, at www.ibx.com/providers/resources/connections.html.

SMART[®] is a registered trademark of Health Dialog Services Corporation.



Osteoporosis and osteopenia: preventing fractures

According to the National Osteoporosis Foundation (NOF), osteoporosis and osteopenia are currently estimated to be a major public health threat for almost 44 million Americans. This represents 55 percent of the population 50 and older. By the year 2010, it is estimated that more than 52 million adults in this same age category will be affected by osteoporosis or osteopenia.

We are reminding our health care providers to take some time to speak with patients about assessment of risk factors, osteoporosis prevention, bone mass density screening, and treatment options, as appropriate.

Risk factors

While osteoporosis and osteopenia are more common in older adults, age is not the only risk factor. Other risk factors include:

- being female;
- family history of osteoporosis;
- personal or family history of broken bones from low-impact falls;
- small, thin frame;
- low sex hormones, including low estrogen levels in women and low levels of testosterone and estrogen in men;
- low calcium and vitamin D intake;
- excessive consumption of protein, sodium, and caffeine;
- inactive lifestyle;
- smoking;
- excessive alcohol consumption;
- taking certain medications such as steroids and some anticonvulsants;
- certain diseases and conditions such as anorexia nervosa, rheumatoid arthritis, and gastrointestinal diseases.

Prevention

The amount of calcium and vitamin D one should consume varies for different age groups.

The NOF recommends:

- adults 19 – 49 receive at least 1,000 mg of calcium and 400 – 800 IU of vitamin D daily;
- adults 50 and older receive at least 1,200 mg of calcium and 800 – 1,000 IU of vitamin D daily.

Calcium intake from diet and supplements should not exceed 2,500 IU daily, and vitamin D intake should not exceed 2,000 IU daily without a physician's specific order and after testing. It is possible to get enough calcium from foods depending on one's diet, but if dietary sources are not adequate, calcium supplements may be needed. Vitamin D supplementation may also be needed.

Some older adult patients are at increased risk for vitamin D deficiency, including those with limited sun exposure, malabsorption diseases (celiac disease), chronic renal insufficiency, housebound patients, and the chronically ill. Patients at increased risk should have their serum 25 (OH)D levels measured. For more information on the prevention of osteoporosis, visit www.nof.org/prevention/index.htm.

Exercise is also important for bone health. Those who exercise regularly in their childhood and adolescence are more likely to reach peak bone density than those who are inactive. Weight-bearing exercise is considered the best type of exercise for your bones. Examples of weight-bearing exercise include walking, dancing, jogging, stair-climbing, racquet sports, and hiking.



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Osteoporosis and osteopenia: preventing fractures (continued)

Screenings

The World Health Organization has developed a 10-year fracture risk model (FRAX[®]), which uses clinical risk factors and bone mineral density at the femoral neck to determine 10-year probability of a major osteoporotic fracture. For more information on FRAX, please visit www.shef.ac.uk/FRAX.

Your personal recommendation for osteoporosis screening and prevention has a tremendous influence on a patient's decision to seek recommended preventive health screenings. Please discuss this important health issue with your patients.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Plan (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Customer Service.

FRAX[™] WHO Fracture Risk Assessment Tool

Ten year probability of osteoporotic fractures (%) according to BMI, the number of clinical risk factors (CRF) and age in women from the US (Caucasian)

Age = 60 years

Number of CRFs	BMI (kg/m ²)						
	15	20	25	30	35	40	45
0	17	12	11	9.8	8.8	7.5	6.6
1	20 (14.25)	18 (13.25)	17 (12.5)	15 (10.9)	13 (9.6)	11 (8.1)	9 (6.6)
2	26 (19.4)	24 (17.9)	24 (18.3)	21 (15.6)	19 (14.3)	17 (12.7)	15 (11.2)
3	40 (29.8)	36 (27.1)	34 (25.4)	30 (22.4)	27 (20.4)	24 (18.1)	21 (15.6)
4	58 (43.7)	49 (36.7)	46 (34.7)	42 (31.4)	37 (28.1)	33 (24.8)	30 (22.7)
5	85 (63.7)	74 (55.7)	70 (52.7)	65 (49.4)	59 (44.7)	53 (40.1)	48 (36.1)
6	122	98	93	86	78	70	63

Age = 65 years

Number of CRFs	BMI (kg/m ²)						
	15	20	25	30	35	40	45
0	16	11	10	9	8	7	6
1	20 (15.3)	18 (13.7)	17 (13.1)	15 (11.5)	13 (10.1)	11 (8.5)	9 (7.1)
2	29 (22.7)	27 (20.7)	26 (20.1)	23 (18.1)	21 (16.7)	19 (15.1)	17 (13.7)
3	46 (35.7)	42 (32.7)	40 (31.1)	36 (28.1)	33 (25.7)	30 (23.7)	28 (21.7)
4	70 (54.7)	64 (49.7)	61 (47.1)	56 (43.7)	51 (39.7)	47 (36.7)	44 (34.7)
5	105 (81.7)	94 (72.7)	90 (69.7)	84 (65.7)	77 (60.7)	72 (56.7)	68 (53.7)
6	155	131	126	117	107	100	94

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Preventive Health

ConnectionsSM AccordantCareTM Resource Specialists provide assistance to patients with complex conditions



Mounting bills and dwindling savings are problems for many Americans, but people with chronic illness face an even harsher reality. Home modifications, transportation problems, equipment access, and caregiver issues add to the burden of those who may not have the energy or ability to cope.

The Connections AccordantCare Program is an added value for our members and their physicians that offers health management services and resource support to those with certain complex, chronic, progressive diseases.

Support begins when a Connections disease management nurse identifies and refers a patient with a specific need to a Resource Specialist. Based on need and patient location, programs are investigated at the national, state, county, and local levels. Here are some ways Resource Specialists help our members and their families connect with needed services.

Home modifications

When disease progression creates a need for a wheelchair ramp or a remodeled bathroom, Resource Specialists consult with organizations at the state level. For example, Delaware's Division of Services for Aging and Adults with Physical Disabilities offers a home modification program. At the county level, community development funds may be available for home changes. When funding dries up, Resource Specialists are trained to drill down to a more local level, perhaps to a volunteer arm of a local carpenters' union to build wheelchair ramps for patients.

Transportation

Members who cannot drive or cannot access public transportation may not be able to get where they need to be — including to their doctor appointments. Resource Specialists look for low-cost transportation options in the member's neighborhood. For example, Paratransit in Pennsylvania offers door-to-door service to eligible riders for \$4 each way.



Medical equipment

State-run assistive technology programs help connect members with adapted vehicles, lifts, augmentative communication devices, and reaching/grabbing aids. New Jersey's Assistive Technology Advocacy Center works to recycle equipment no longer being used and place it into the hands of those who need it.

Food

Most areas have sources for emergency food, such as a local food bank. Resource Specialists search for additional sources, including charitable organizations that provide food for those in need. Many patients have benefited from Angel Food Ministries, a nondenominational outreach program that offers food relief (including meat) in communities throughout the United States.

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ConnectionsSM AccordantCareTM Resource Specialists provide assistance to patients with complex conditions (continued)

Local counseling

When depression accompanies chronic illness, it can prevent patients from complying with treatment. Resource Specialists find local support groups and encourage members and their families to get involved. The Resource Specialist will make follow-up calls to members and encourage them to participate in these groups.

Respite care

Caregivers experience burnout, especially if they also work and take care of children. Respite care provides much needed time away for caregivers, and it provides social interaction for the member. Resource Specialists help caregivers find nearby family support programs.

Benefits and financial resources

Resource Specialists explore patient eligibility for programs like Social Security Disability, social service department benefits, pension plans, veteran's benefits, and Medicare. Guidance is provided to members who may feel intimidated by the application process, and Resource Specialists answer specific questions to take the mystery out of filling out those forms.

Mary Craver, a Resource Specialist with the Connections AccordantCare Program, says: "It can be very difficult for individuals, even if they do not have medical issues, to access resources and services that might be available to them. Combine navigation of the system with illness and disability, and the process becomes even more overwhelming."

Resource Specialists are particularly valuable in a troubled economy, where they can step in to meet needs beyond the reach of other resources available to members. To refer a patient to or obtain additional information about the Connections AccordantCare Program, call toll-free 1-866-398-8761.

Independence Blue Cross offers additional support

The Case Management department has registered nurse case managers and licensed social workers available to assist providers with patients who have complex or serious medical conditions. Their primary role is to coordinate patient care needs and resources with their health care providers. Case management services are provided at no extra cost to the patient.

The services provided include, but are not limited to:

- educating members on available benefits and programs;
- helping members navigate the health care and social service systems;
- offering resources to promote medication adherence;
- assisting patients and families in coping with the emotional and financial impacts of the illness or condition;
- recommending support groups and other services for additional information and reinforcement;
- locating and recommending community resources;
- coordinating services with the health care provider for a comprehensive approach to patient care outside of the office.

Personal support for your patients is only a phone call away. To reach a case manager or social worker, call [1-800-313-8628](tel:1-800-313-8628) and press prompt 3.



Important Resources

American Imaging Management (AIM) Call for CT, MRI/MRA, PET, and Nuclear Cardiology	1-800-ASK-BLUE
Care Management and Coordination Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles SM Keys to Wellness	215-567-3570 1-800-313-8628*
ConnectionsSM Health Management Programs Connections SM Health Management Program Provider Support Line	1-866-866-4694
Connections SM AccordantCare TM Program	1-866-398-8761
Corporate and Financial Investigations Department Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
Credentialing Credentialing Hotline	215-988-6534 www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
Customer Service (Policies/Procedures/Claims) HMO and PPO	1-800-ASK-BLUE, prompt 1 for Member Services 1-800-ASK-BLUE, prompt 2 for Provider Services
eBusiness Help Desk	215-241-2305
FutureScripts® Prescription Drug Authorization Toll Free Fax	1-888-678-7012 1-888-671-5285
Direct Ship Injectable Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-678-7012
FutureScripts® Secure Medicare Part D	1-888-678-7015
Formulary updates	www.site65.com
Health Resource Center Healthy Lifestyles SM	1-800-ASK-BLUE
Precertification	1-800-ASK-BLUE
Interactive Voice Response (IVR) system	1-800-ASK-BLUE, prompt 2
NaviNet® Portal Registration	www.ibx.com/providers/navinet/index.html
Provider Medical Policy Web Page	www.ibx.com/medpolicy
Provider Pharmacy Web Page	www.ibx.com/provider_rx
Provider Supply Line	1-800-858-4728

* Outside 215 area code



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Summary of benefits changes



Benefits language was enhanced for the services listed below:

TYPE OF SERVICE	NATURE OF ENHANCEMENT
Cardiac rehabilitation	The benefit has been expanded from 18 to 36 sessions per calendar year.
Nutrition counseling	Added benefit that provides members with six free nutritional counseling visits per year.
Preventive health	An enhancement has been made to the Personal Choice preventive health schedule for coverage of routine osteoporosis screening (bone density) studies for members age 65 and older.
Routine costs associated with qualifying clinical trials	Routine costs associated with qualifying clinical trials are covered if certain conditions are met.
Spacers for metered dose inhalers	Previously, these devices were covered under the durable medical equipment (DME) benefit. To further enhance members' access to these devices, spacers for metered dose inhalers will be covered under the prescription drug benefit as well as the DME benefit. When spacers for metered dose inhalers are purchased under the prescription drug benefit, the appropriate member cost-sharing will apply.

Benefits language was clarified for the services listed below:

TYPE OF SERVICE	NATURE OF CLARIFICATION
Alternative therapies	Language has been added to clarify the exclusion of alternative therapies under members' health plans.
Ambulance transport	Language has been added to explain the difference between the benefit and cost-sharing of emergency ambulance care and non-emergency ambulance care.
Appeals	New language explains that the appeals process, based on medical necessity, now includes an additional third level of appeal to an external independent review organization.
Cataract glasses	The description of prosthetics has been clarified regarding coverage for cataract glasses and other vision prosthetics.
Cognitive rehabilitation therapy	New definition and exclusion language were added to clarify coverage of cognitive rehabilitation therapy.
Cosmetic surgery	Language regarding cosmetic surgery performed to correct a condition resulting from an accident was clarified to state that the individual does not have to be a member at the time the accident occurred.
Day rehabilitation programs	Language has been clarified to indicate that day rehabilitation services are subject to 30 sessions maximum per calendar year. Preapproval is required.
Diabetic education	Language expands the benefit so that professional providers, in addition to facility providers, are eligible to perform diabetic education. Services must be performed by a network provider.
Emergency care and services	The emergency care definition and the emergency services description of coverage has been revised.
Extension of student dependent coverage for military service (PA Act 83)	Language has been added to provide an extension of eligibility of coverage for covered dependents who are full-time students called to active military service.
Hearing aids	A new hearing aid definition has been added.
Home health care	The definitions of "home" and "homebound" status were clarified.
Licensed clinical social workers (LCSW)	Language has been added to allow members to access LCSWs for covered outpatient mental health services provided by out-of-network LCSWs.
Mammography	Language has been clarified to eliminate age and frequency limitations for diagnostic and routine mammography. Now, diagnostic mammograms will be covered with no in-network cost-sharing, as is currently the case for routine mammograms.
Masters prepared therapist	A definition of masters prepared therapist has been added so services performed by this type of professional provider will be covered.
Medical necessity	Language has been revised so that there is a single definition, which reflects industry standards across all Independence Blue Cross (IBC) benefit programs.
Orthognathic surgery	Description of oral surgery benefits is expanded to explain conditions for coverage.
Orthoptics/pleoptics	Language has been added to clarify the benefit and to limit these services to eight visits per lifetime.

(over)

Benefits language was clarified for the services listed below: (cont.)

TYPE OF SERVICE	NATURE OF CLARIFICATION
Post-mastectomy care/home health care and lymphedema	Surgical services and home health care language have been clarified to describe the benefits provided for post-mastectomy care and treatment of lymphedema associated with mastectomies.
Premium rates	Language has been added to describe premium adjustments made in response to a change in a member's age. New premium rates may be adjusted upon approval by the Pennsylvania Insurance Department.
Prescription drug rebate language	Language has been clarified regarding the prescription drug rebate program.
Provider reimbursement	Language has been revised to clarify how IBC reimburses providers for covered services.
Residential treatment centers	Language has been clarified to state that a residential treatment facility is an eligible provider not only for substance abuse treatment but also for treatment of mental illness.
Special circumstances	Language has been added to outline IBC's ability to waive certain contract requirements (e.g., waive preapproval requirements or use of participating providers) when faced with unforeseen events, such as a natural disaster or pandemic.
Utilization management	Language has been added to describe the utilization management process.
Waivers	Language has been revised to describe the process by which IBC authorizes and reimburses for the use of an out-of-network provider when no in-network provider is able to perform covered services required for the patient's condition.

Benefits language was updated regarding preapprovals:

TYPE OF SERVICE	NATURE OF CHANGE
Bariatric surgery	Language has been added to clarify that a revision/reversal/redo of elective obesity surgery is not covered services unless it is required as a result of complications or true surgical failure. Precertification is now required for bariatric surgery regardless of the place of service.
Diagnostic imaging	Language has been clarified to require providers to obtain preapproval for MRI/MRA, CT/CTA scans, and PET scans.
Durable medical equipment (DME)	Previously, DME with a purchase price of more than \$100 required preapproval. Now, only DME purchases of more than \$500 will require preapproval. When deemed medically necessary by IBC, defective or damaged equipment will be repaired or replaced. Home blood pressure machines and motorized wheelchairs will be covered in certain instances within program guidelines.
Infusion services	Coverage for infusion services was clarified to reflect that these services are not limited to infusion services provided in the home.
Infusion therapy drugs	Precertification is now required for the drugs listed below that are given by infusion therapy when provided in an outpatient facility or in a professional provider's office: Aldurazyme®, Aredia®, Avastin®, Boniva®, Ceredase®, Cerezyme®, Elaprase®, Erbitux®, Fabrazyme®, Genasense®, Herceptin®, IVIG, Myozyme®, Orencia®, Remicade®, RespiGam®, Tysabri®. Infusion drugs that are newly approved by the U.S. Food and Drug Administration (FDA) are considered new and emerging technology and will be subject to precertification, pending notification by the carrier.
Prosthetics and orthotics	Previously, prosthetics with a purchase price of more than \$100 required preapproval. Now, only prosthetics and orthotics with a purchase price of more than \$500 will require preapproval. Also, when deemed medically necessary by IBC, the repair and replacement of prosthetic devices is now covered.
Therapy services and restorative	The precertification requirements were removed for physical therapy, occupational therapy, and restorative services. Services may be subject to denial upon retrospective review of medical necessity.



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